

VIRGINIA INFORMED CHOICE

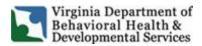
- The Virginia Informed Choice (VIC) is required for individuals who are newly enrolled or currently have a DD Waiver
- Retain a copy of the signed document in the individual's file
- Review and complete the VIC with the individual and/or substitute decision-maker (SDM) at the following times:
 - <u>Annually</u>
 - At Enrollment into the Developmental Disability (DD) Waivers:
 - Building Independence (BI)
 - Family and Individual Supports (FIS)
 - Community Living (CL)
 - When there is a request for a change in waiver provider(s)
 - When new services are requested
 - When the individual wants to move to a new location and/or is dissatisfied with the current provider
 - When making a Regional Support Team (RST) referral for individuals with a DD Waiver
 - Submit the VIC with the RST Referral to the secure RST mailbox: <u>RST.Referrals@DBHDS.virginia.gov</u>

Date Completed:				
	Substitute Decision			
DD Waiver Type:	iviaker.			
1. Discuss each applicable HCBS service prio	<mark>to assisting the individual with identifyin to the restiventify in the restingtion of the restination of th</mark>	ng Waiver service options		
2. Confirm discussion of all applicable waive	r service options by checking the options I	isted below		
Residential Options N/A 🗆	Employment and Day Options N/A 🗆	Additional Options	N/A □	
☐ Independent Living Supports (BI Waiver Only)	☐ Individual Supported Employment	☐ Peer Mentoring	☐ Community Guide	
☐ Shared Living	☐ Group Supported Employment	☐ Assistive Technology	☐ Benefits Planning	
☐ Supported Living	☐ Workplace Assistance Services	☐ Transition Services	☐ Support Coordination	
☐ In-home Support Services	☐ Community Engagement	☐ Environmental Modifications		
☐ Sponsored Residential		☐ Electronic Home-Based Services		
☐ Group Home Residential 4 beds or less	☐ Community Coaching ☐ Employment and Community Coaching		unity Transportation	
☐ Group Home Residential 5 beds or more (RST req'd)	☐ Group Day Services	☐ Individual and Family/Caregiver Training (FIS Waiver Only)		
Medical and Behavioral Support Options $$ N/A \Box	Crisis Support Options N/A 🗆	Agency-Directed Consume	r-Directed 🗆 N/A 🗆	
☐ Skilled Nursing (FIS & CL Waivers Only)	☐ Community-Based Crisis Supports	☐ Consumer-Directed Services Facilitation (FIS & CL Only)		
☐ Private Duty Nursing (FIS & CL Waivers Only)	☐ Center-Based Crisis Supports	☐ Personal Assistance Services (FIS & CL Waivers Only)		
☐ Therapeutic Consultation (FIS & CL Waivers Only)	☐ Crisis Support Services	☐ Respite (FIS & CL Waivers Only)		
☐ Personal Emergency Response System (PERS)		☐ Companion (FIS & CL Waivers Only)		
SC has provided the opportunity to talk with other	You may contact a DBHDS Family Resource	Provider options are available	on the DBHDS Licensing	
individuals receiving BI/FIS/CL Waiver services who	Consultant at (804) 894-0928 or (804) 201-	website and the DBHDS Provider Survey		
live and work successfully in the community or with	3833 to connect with individuals and	http://lpss.dbhds.virginia.gov/LPSS/LPSS.aspx		
their family members Yes \square No \square	families who have waiver services	http://ejiujiu0.wixsite.com/pro	<u>ovidersurvey</u>	
3. List multiple providers in each section if a	pplicable and indicate option selected			

3. List multiple providers in each section if applicable and indicate option selected In making a decision, I/we considered the following Options:

Options	Provider Agency, Location (City) and Bed Capacity	Option Selected	Reason(s) Selected/Denied (Be specific)
Support Coordination			

Individual's Name:	Page 1 of 2	Informed Choice DMAS-460 rev. 8/3/18



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3. List multiple providers in each section if applicable and indicate option selected In making a decision, I/we <u>considered</u> the following Options:

Options	Provider Agency, Location (City) and Bed Capacity	Option Selected	Reason(s) Selected/Denied (Be specific)
may contact my Support	Coordinator/Case Manager (SC/CM) to seek assista	nce with resolving pro	vider-related issues. I have the
option of changing provid	ers, including my SC/CM. I have the right to a fair he	earing and appeal proc	ess. I may be responsible for some
service cost (patient pay),	based on my income. If I chose Consumer-Directed	Services, I am respons	sible for employing my own personal
assistants and know there	e are services in the BI/FIS/CL Waivers that require a	backup plan if there is	a lapse in services. I will actively
participate in the develop	ment of my Person-Centered Individual Support Pla	ın.	
My SC/CM discussed the	above information with me.		
iviy 5c/ civi discussed the	above information with me.		
ndividual Signature/Date	SDM Signature (if applicable)/Date	SC/CM Signature/Date	
	of could propupe the confidential attention		
-	eferral is REQUIRED if any of the following criteria	<u>арріу:</u>	
Community: □ Difficulty finding convic	tes in the community within 3 months of receiving a	clot	
	ne of five or more individuals	SIOL	
\square Moving to a group non \square			
_	peing removed from home		
□ Fattern of repeatedly in	Jenig removed from nome		
	ome, ICF/ID or group home with five or more individ	luals	
-	cular type of community supports within 30 days of		
	discharge plan outcome within 15 days of the annu	- '	nin 30 days after the admission to the
Training Center	anoman Be prant outcome minim 20 days of the annua	a .	
•	es moving despite PST recommendation		
	s to participate in the discharge planning process		
	nree months of selecting a provider		
	emain in a Training Center		